PROCEEDINGS OF THE

GOVERNOR'S FIRST CONFERENCE ON THE HANDICAPPED

1961

Foreword

THE purpose of the Governor's First Conference on the Handicapped, as stated by Governor Welsh, was to "bring together those persons who are working with the handicapped of Indiana, through the many public and private agencies and organizations in this field, for a two-day study and discussion session concerning some of the major problems which face our total rehabilitation effort."

This purpose was realized. It was inspiring to observe the excellent response to the Governor's invitation, and to work with such dedicated individuals in the atmosphere of cooperation which prevailed at the conference. I believe this meeting may well mark the beginning of a more coordinated effort for the handicapped of this state.

We have prepared the proceedings of the conference with a great deal of pleasure, and it is our sincere hope that real progress will result from the study and application of the many suggestions and recommendations which are the tangible products of the meeting.

Andrew C. Offutt, M.D.
State Health Commissioner

PROCEEDINGS OF THE

GOVERNOR'S

First

CONFERENCE ON THE HANDICAPPED

MAY 10-11, 1961

INDIANA MEMORIAL UNION BUILDING
INDIANA UNIVERSITY
Bloomington, Indiana

Rehabilitation's Future
In Indiana

THE COMMISSION FOR THE HANDICAPPED

Neal E. Baxter, M.D., *Chairman*
Bloomington

Ralph N. Phelps, *Vice-Chairman*
Indianapolis

Theodore Dombrowski, *Secretary*
Executive Secretary, Lake County Society for Crippled Children and Adults
Gary

Ralph Biery
Business Representative, AFL-CIO
Dayton

Joseph W. Elbert, D.O.
Petersburg

Stewart T. Ginsberg, M.D.
Mental Health Commissioner
Division of Mental Health
Indianapolis

Frank McKinley Hall, M.D.
Medical Director
State Department of Public Welfare
Indianapolis

Howard G. Lytle, Director
Indianapolis Goodwill Industries
Indianapolis

Ralph McDonald, D.D.S.
Indiana University School of Dentistry
Indianapolis

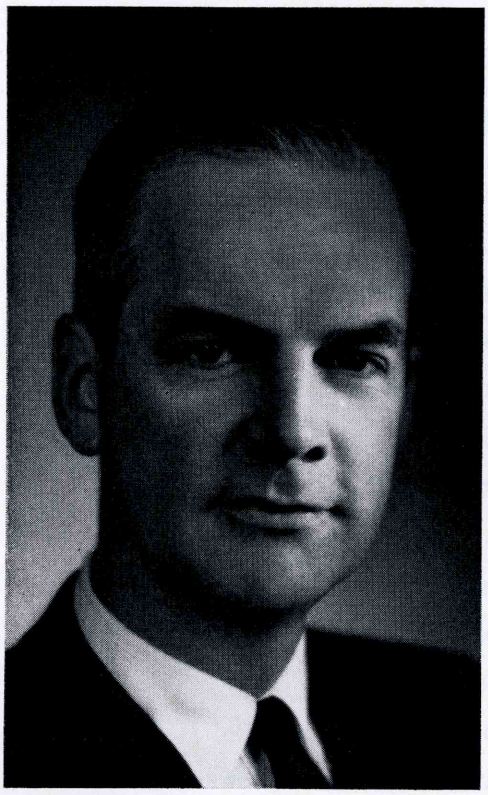
Tony C. Milazzo, Director
Division of Special Education
State Department of Public Instruction
Indianapolis

Alexander T. Ross, M.D.
Chairman, Department of Neurology
Indiana University School of Medicine
Indianapolis

Mrs. Carolyn C. Tucker
Supervisor of Volunteers
Crossroads Rehabilitation Center
Indianapolis

Executive Secretary
Charles E. Henley, Director
Division for the Handicapped
Indiana State Board of Health
Indianapolis

THE GOVERNOR'S FIRST CONFERENCE ON THE HANDICAPPED



Matthew E. Welsh, *Governor*
State of Indiana

"Rehabilitation is the process of decreasing dependency of the handicapped or disabled person by developing to the greatest extent possible those abilities needed for adequate functioning in his individual situation."—*From the American Journal of Public Health, September (1960).*

Contents—

THE PROGRAM

PROGRAM

Wednesday, May 10, 1961

Morning

9:00 Registration—Conference Lounge
Coffee Hour*—Conference Lounge

9:30 Briefing for discussion leaders—Room G 9-11
Robert Yoho, H.S.D., Presiding

10:30 *First General Session*—Whittenberger Auditorium
A. C. Offutt, M.D., Presiding
Invocation—Reverend Joseph Walker, First Presbyterian Church, Bloomington
Welcome—Dr. Offutt
Welcome—Ralph L. Collins, Ph.D.
Address: "Conference Background, Aims, and Objectives"
Speaker: Neal E. Baxter, M.D.

11:30 Luncheon—The Georgian Room
Ralph Phelps, Presiding

Afternoon

1:00 *Second General Session*—Whittenberger Auditorium
Theodore Dombrowski, Presiding
Address: "Problems in Recruiting and Training Rehabilitation Personnel"
Speaker: Jayne Shover

2:00 *First Discussion Session*
Topic: Discussion of present personnel shortages and the consideration of recommendations for a coordinated attack on this problem.
Special Interest Groups and Discussion Leaders
Medical and Dental Room G 45
(physicians, dentists, nurses, occupational therapists, and physical therapists)
Discussion Leader—
Morris Green, M.D.
Social Workers Room G 40-42
Discussion Leader—Patricia Beall
Educators Room G 44-46
Discussion Leader—Kenneth N. Orr
Recreation Workers Room 300 A
Discussion Leader—
Janet MacLean, Re.D.
Sheltered Workshop Personnel
Room 400 A
Discussion Leader—Paul Schmidt
Psychologists Room G 41-43
Discussion Leader—
Gordon Barrows, Ph.D.
Speech and Hearing Pathologists
Room G 15
Discussion Leader—
Robert Milisen, Ph.D.
Vocational Rehabilitation Counselors
Room 500 A
Discussion Leader—Freeman Ketron
Administrators Room 300 B
Discussion Leader—
Spiro Mitsos, Ph.D.

3:30 *Third General Session*—Whittenberger Auditorium
Howard Lytle, Presiding
Panel Discussion—Topic: "Obstacles to the Employment of the Handicapped in Indiana."
Panel Members:
Roy E. Patton, Moderator
Edward L. Jewell
Jacob R. Roberts
Ben Small, LL.D.
Emet C. Talley

4:30 *Open Discussion Period*

7:00 *Banquet*—Frangipani Room
Neal E. Baxter, M.D., Presiding
Invocation—Reverend Ellison Cole, Trinity Episcopal Church, Bloomington
Welcome—The Honorable Matthew E. Welsh, Governor of Indiana
Address: "Serving the Handicapped at Home and Abroad"
Speaker: Mary E. Switzer
Indiana Rehabilitation Association Awards
Presentation—
H. Glenn Gardiner, M.D.

Thursday, May 11, 1961

Morning

9:00 *Fourth General Session*—Whittenberger Auditorium
Frank M. Hall, M.D., Presiding
Address: "Let George Do It"
Andrew C. Offutt, M.D.
Coffee Break*—State Rooms—East and West

10:00 *Second Discussion Session*
Topic: The identification of additional major problem areas in Indiana's rehabilitation effort and the consideration of recommendations for cooperative action toward the general improvement of the total program for the handicapped of the State.

Special Interest Groups and Discussion Leaders

Blindness and Visual Problems Room 400 A
Discussion Leader—Durward Hutchinson

Neurological Problems Room 300 B
Discussion Leader—Arthur L. Drew, M.D.

Orthopedic Conditions Room G 41-43
Discussion Leader—Carl D. Martz, M.D.

Mental Retardation Room G 45
Discussion Leader—Tony C. Milazzo

Speech Problems Room G 44-46
Discussion Leader—James Shanks, Ph.D.

Deaf and Hard of Hearing Room G 15
Discussion Leader—William McClure, L.H.D.

Mental Illness Room G 40-42
Discussion Leader—John Southworth, M.D.

Chronic Diseases Room 300 A
Discussion Leader—H. Glenn Gardiner, M.D.

12:00 *Luncheon*—The Georgian Room
Neal E. Baxter, M.D., Presiding
Reading and Approval of Group Session Reports and Recommendations.
Conference Adjournment

Afternoon

2:00 Post Conference Session Room G 41-43
Robert Yoho, H.S.D., Presiding
"The Utilization of Rehabilitation Centers"
A report and discussion of a Regional Workshop on the Utilization of Rehabilitation Centers, held at Michigan State University, June 1-3, 1960.

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* Courtesy of the Indiana Rehabilitation Association.

CONFERENCE DIRECTORY

Speakers

The Honorable Matthew E. Welsh
Governor, State of Indiana

Neal E. Baxter, M.D., Chairman
Commission for the Handicapped
Indiana State Board of Health
Indianapolis

Ralph L. Collins, Ph.D.
Vice-President and Dean of Faculty
Indiana University
Bloomington

Andrew C. Offutt, M.D.
State Health Commissioner
State of Indiana

Jayne Shover, Associate Director
National Society for Crippled Children and Adults
Chicago, Illinois

Mary E. Switzer, Director
Office of Vocational Rehabilitation
Department of Health, Education and Welfare
Washington, D.C.

Panel Members

Edward L. Jewell
Personnel Director
Herff Jones Company
Indianapolis

CONFERENCE DIRECTORY (Continued)

Roy E. Patton, Director
Crossroads Rehabilitation Center
Chairman, Governor's Committee for the Employment of the Handicapped
Indianapolis

Jacob R. Roberts, Vice-President
Indiana State AFL-CIO
Indianapolis

Ben Small, LL.D.
Associate Dean
Indiana University School of Law
Indianapolis

Emet C. Talley, Supervisor
Employment Counseling
Indiana Employment Security Division
Indianapolis

Discussion Leaders

Gordon A. Barrows, Ph.D.
Consultant in Clinical Psychology
Division of Mental Health
Indianapolis

Patricia Beall, Director
Social Service Department
Indiana University Medical Center
Indianapolis

Arthur L. Drew, Ph.D.
Professor of Neurology
Indiana University Medical Center
Indianapolis

H. Glenn Gardiner, M.D.
Director, Medical Department
Inland Steel Company
East Chicago

Morris Green, M.D.
Director, Diagnostic and Outpatient Center
Riley Hospital
Indiana University Medical Center
Indianapolis

Durward A. Hutchinson, Superintendent
Indiana School for the Blind
Indianapolis

Freeman D. Ketron, Chief
Guidance, Counseling and Training
Vocational Rehabilitation Division
Indianapolis

Janet R. MacLean, Re.D.
Assistant Professor of Recreation
School of Health, Physical Education and Recreation
Indiana University
Bloomington

Carl D. Martz, M.D.
Indianapolis

William J. McClure, L.H.D., Superintendent
Indiana State School for the Deaf
Indianapolis

Tony C. Milazzo, Director
Division of Special Education
Department of Public Instruction
Indianapolis

Robert Milisen, Ph.D., Director
Speech and Hearing Clinic
Indiana University
Bloomington

Spiro B. Mitsos, Ph.D.
Executive Director
The Rehabilitation Center
Evansville

Kenneth N. Orr, Assistant Professor
Department of Special Education
Indiana State Teachers College
Terre Haute

Paul Schmidt
Director of Rehabilitation Services
Indianapolis Goodwill Industries, Inc.
Indianapolis

James C. Shanks, Jr., Ph.D.
Clinical Director
Speech Pathology Services
Audiology and Speech Clinic
Indiana University Medical Center
Indianapolis

John W. Southworth, M.D.
Deputy Mental Health Commissioner
Division of Mental Health
Indianapolis

Robert Yoho, H.S.D.
Indiana State Board of Health
Indianapolis

MAJOR ADDRESSES

Following is the text of an address given by Neal E. Baxter, M.D., Chairman of the Commission for the Handicapped.

We meet here today to participate in the first program of its kind ever to be held in the State of Indiana . . . The Governor's First Conference on the Handicapped. This meeting was not developed overnight but is the result of a series of events, beginning some fourteen years ago, which have led us naturally to such a conference. I would like to briefly review with you some of these events.

The Indiana Planning Committee on Rehabilitation was formed in 1947 by representatives of several official and volunteer agencies for the purpose of coordinating the rehabilitation efforts of the various member agencies. This committee was active for 10 years working on an unofficial and volunteer basis. It was finally decided by the committee that a full-time official agency was needed to carry on this work and in 1957 legislation was prepared which was designed to create a State Commission for the Handicapped. This legislation was not enacted.

The Governor's Commission for Physically Handicapped Children was created by the Indiana General Assembly also in 1947. The purpose of this Commission as set forth in the legislation was: to study conditions relating to physically handicapped children in Indiana and in other states with a view toward improving the facilities and services available to such children through recommendations to administrative and legislative bodies.

After the failure of the 1957 legislative proposal, the Governor's Commission for Physically Handicapped Children, feeling that this type of approach was vital to the growth of the total rehabilitation program in Indiana reworked the legislation and presented it to the 1959 General Assembly where it passed, becoming Chapter 91 of the Acts of 1959.

It is in this way that the present Commission for the Handicapped came into being.

The purpose of this legislation as stated in the act is: to provide a facility charged with the responsibility of providing direction and leadership in the development of comprehensive rehabilitation programs for the handicapped of this state.

The duties of the Commission as set forth in the legislation are as follows:

1. Maintain a central register of the handicapped. Methods of accomplishing this goal are being studied by the Commission. The thinking of this conference concerning this matter would be of great interest to the Commission.
2. Discover and identify, within the state, rehabilitation services and opportunities for the handicapped. A survey of existing agencies and facilities for the handicapped has been made and you have probably received a copy of the new Directory of Services for the Handicapped which is a result of this survey.
3. Promote the training and recruitment of rehabilitation personnel. We will be considering this problem later today.
4. Conduct a public relations program dealing with the problems of rehabilitation.
5. Offer assistance to local communities in the development of programs designed to meet the needs of the handicapped. A Commission program is now underway to encourage and aid communities in the development of local committees for the handicapped.
6. Coordinate the efforts of the various official and voluntary agencies providing services for the rehabilitation of the handicapped within the state.

Although, as I have indicated, the Commission has initiated work in most of the areas of responsibility assigned to it, in a very real sense this conference today marks the first major accomplishment of the Commission. We meet here to begin the drafting of plans for the future of rehabilitation in Indiana. We meet at the call of the Governor to attack some of the vital problems which we face. Those attending this conference represent a wide variation in profession, speciality, agency type, and special interest. No doubt, this conference is the most inclusive of any ever called in Indiana concerning the handicapped.

From this conference may come a new approach to planning and coordination for the handicapped in Indiana. Or, out of this conference may come nothing. It depends upon us—each of us—to do his best to make this meeting a success.

We come here to deliberate upon a campaign which lies ahead. A campaign against disability.

A campaign also against the allies of disability—ignorance, fear, indifference, and despair. We do not come to this council as green troops, however; we come as seasoned fighters from many fronts. We have fought for the cause of the crippled, the blind, the deaf, the retarded, the mentally ill, and many others. Our battle cry has been the same, "Give our people a helping hand that they may take their place beside you as productive citizens." Gains have been made on all fronts but the individual battles which we have left for today will and must continue.

And yet, as we fight, the picture of the total campaign becomes clearer. We find that the army on our right and left flanks attack the same enemy. We begin to see that better cooperation among ourselves will give us greater strength. And, so we meet here together today with all of our forces represented for the first time. We meet to plan a united attack against two of the enemy's great strongholds. We meet to consider future strategy which will lead to his ultimate defeat. Let us reason well together, because the fate of many depend upon the total victory.

Following is the text of an address given by Miss Jayne Shover, Associate Director of the National Society for Crippled Children and Adults, Inc.

"Problems in Recruiting and Training Rehabilitation Personnel"

The story of our changing and growing population has been well told through our channels of communication, and we are well aware of the problems which these trends have brought. We must recognize that sharply rising population figures and the increasing longevity which science has given us will result in even greater numbers of our population needing rehabilitation services. The 16 million aged Americans and the 20 to 30 million persons afflicted with chronic disease and disabilities bring into sharp focus the tremendous need for rehabilitation services. Some are children at the dawn of life, others are senior citizens who have given rich service during many years of life. They need and deserve our help. Can we meet the challenges they present (which rehabilitation offers us)?

Rehabilitation today is not a cluster of segregated professions performing isolated services to individuals, but a synthesis of many disciplines functioning to utilize every ability of the handicapped child or adult and every asset of the community to enable him to live as happily, usefully, and independently as possible. The total concept of rehabilitation—which brings together the physician; nurse; physical, occupational and speech therapist; psychologist; teacher; social worker, vocational counselor; and many others—has demonstrated its effectiveness. The need now is for more and more personnel to implement it.

That the shortage of carefully selected and properly trained personnel continues to be the greatest single obstacle to the growth of rehabilitation facilities has been recognized by many groups.

In 1952, the Task Force on the Handicapped of the Office of Defense Mobilization repeatedly emphasized the national shortage of trained paramedical personnel concerned with rehabilitation, and made concrete suggestions for increasing the national supply.

In 1955, the National Health Council, with financial support of the Equitable Life Assurance Society, published "Health Careers Guidebook" and supplementary materials which give a capsule on 150 health careers.

Later, the President's Committee on the Health Needs of the Nation highlighted the critical personnel shortages in a special report, "Mobilization and Health Manpower."

The Office of Vocational Rehabilitation has expressed its concern by encouraging advancement in health professions by instituting a training grant program for colleges and universities.

The National Conference on Care of Long-Term Patients strongly recommended attention to the manpower needs in health and rehabilitation.

Major voluntary health organizations, particularly The National Foundation and the National Society for Crippled Children and Adults, have for almost two decades continued to emphasize the need and have offered fellowships and scholarships for basic and advanced training.

The concern of these groups becomes quite evident when a review is made of the available personnel in specific professional fields:

Medicine

First-year enrollments in the medical schools of our country now total over 8,000. By 1970, that figure will need to grow to 10,500 or 11,000, and twelve new four-year medical schools will be needed. Another twelve schools will be required by 1976.

There is need for further integration into medical school curricula of a greater concern for the needs of the chronically ill and handicapped, of a greater understanding of the contribution of associated personnel, and of social, psychological factors in rehabilitation services.

There is need to bring more rapidly and effectively to the physician in practice the new and successful procedures in the rehabilitation of the disabled.

Physical Therapy

Physical therapy is the treatment of patients with disabilities resulting from disease or injury, by use of the therapeutic properties of exercise, heat, cold, water, light, electricity, sound, and massage. A physical therapist, following treatment prescribed by the patient's physician, administers such care to patients. It is one of the key rehabilitation services for many persons.

Physical therapists are employed in physical therapy departments of general hospitals, physicians' offices, crippled children's services, rehabilitation centers, community health programs, the armed forces, colleges and universities offering programs in physical therapy, and hospitals for the chronically ill and elderly.

The American Physical Therapy Association is concerned about the fact that the forty approved schools of physical therapy are under-enrolled. At least 1,000 additional students could be accepted, an increase of 25 percent over the present enrollment.

The Placement Services of the American Physical Therapy Association gave assistance to over 1,000 facilities in 1960 in their search for qualified personnel. At the present time, there are approximately 450 facilities in need of almost 600 physical therapists. It is interesting to note that 60 percent of these openings are for experienced physical therapists who are able to develop a new service, or expand an existing facility to provide for some type of specialized service.

Occupational Therapy

Occupational therapy is defined as "remedial activity prescribed by a physician for those who are physically or mentally ill, disabled by accident, disease or age, or with birth defects." Treatment programs, supervised by registered occupational therapists, include creative and manual arts, recreational activities, educational and prevocational training, and activities of daily living. Occupational therapy aims to improve the patient's physical function; and to promote the patient's adjustment psychologically, socially, and economically.

There are presently 6,107 registered occupational therapists in this country. The need projected to 1962 calls for an additional 15,000. Realizing how important this professional discipline is, we are still far too complacent about the inadequate supply. However, the American Occupational Therapy Association is forging ahead to relieve the shortage through regional recruiting institutes and workshops.

Speech Therapy

It has been estimated that five percent of our school-age children (five to nineteen years), or a total of 2,489,000 children, require speech rehabilitation services. Three percent of the persons over nineteen years of age also require such services, making a total of 8,938,371 persons in need of speech rehabilitation. Of the 20,000 speech and hearing specialists needed at present, only one third are now available. Only 400 a year are being trained. None of the 70 training schools offering advanced degrees is over-subscribed. To meet the need in the years ahead, 1,500 speech rehabilitation personnel should be trained each year for the next ten years. This is a vivid example of a demand far exceeding the supply.

Social Work

The social worker functions in many settings and draws upon community resources in his effort to assist the patient and family to accept a diagnosis with courage and understand and adjust to the problems associated with illness, age, or disability. The 10,000 medical and psychiatric social workers must be tripled to meet present shortages. More medical, psychiatric and group social workers are needed in rehabilitation programs as a result of our increased awareness of the significant role social and emotional factors play in motivating disabled persons to seek and benefit from rehabilitation services.

Psychology

Psychology, both in its clinical and counseling aspects, is a key profession in rehabilitation. There is need for 10,000 to 12,000 clinical psychologists. The existing shortage is made more acute by the fact that many persons with degrees in psychology have been siphoned off into the motivational aspects of the advertising industry and into communication fields.

Rehabilitation Counseling

Rehabilitation counseling is a synthesis of many disciplines utilized principally at the present time by the Office of Vocational Rehabilitation. The National Rehabilitation Association has given major emphasis to reviewing requirements and establishing standards in this new field. The 2,000 rehabilitation counselors presently employed are barely adequate to serve the increasing numbers of disabled persons seeking rehabilitation.

Education

The Office of Education reports that the number of exceptional children in the special education programs in our local public school systems has more than doubled from about 378,000 in 1948 to nearly 861,000 in 1958. Add to this growing need the acceleration of interest in nursery schools and kindergarten and we shall have some idea of the future needs for personnel in this area. The greatest obstacle to improving and expanding programs to care for the increasing numbers of American children who have special education needs is the shortage of qualified teachers.

Clearly, the number of personnel must be increased by more effective recruitment, by the availability of scholarship funds to supplement individual resources, and by making salaries and fringe benefits more attractive.

It is essential that training programs for rehabilitation personnel present a clear understanding of the objectives and functions of all other disciplines in rehabilitation services, a lucid picture of how all the disciplines work together in a synthesizing of the rehabilitation facets for a comprehensive patient plan. Speech rehabilitation students, for example, should be fully aware of the role of medicine in the rehabilitation of patients with organic speech disorders. They must likewise be able to work in an enlightened manner with the clinical and counseling psychologists; the medical, psychiatric and group social workers; the physical and occupational therapists; and the nurse.

Training programs must insure that students, to an ever greater degree, see the patient in relation to his environment, family and community. They must be better informed about community resources and how they can be interwoven into the rehabilitation plan—social and spiritual resources as well as health and economic.

Curricula changes in training programs are also necessary to equip personnel to care more effectively for the severely handicapped, the chronically ill, and the aged. In our culture there continues to exist a rejection of the aged and disabled. It exists not only in the general public, but in the professions as well. The care of the chronically ill, the aged, and the severely handicapped is too often regarded as uninteresting, unchallenging, and less rewarding than that of the acutely ill. For far too many it is physically taxing, unattractive and discouraging; the facilities seem uninspiring, patient-staff ratios may be too heavy, the hours too long.

A chief of pediatrics at a large state university has been earnestly seeking research funds with which to study methods of instilling in pediatricians a greater incentive to serve the severely handicapped child—of changing psychologically the aura of disinterest. He is challenged to modify the traditional aim of medical teaching . . . "that all patients should get well."

This is not an easy task. In the development of medical interest in the early days of the National Cerebral Palsy Program of the Easter Seal Societies, the greatest obstacle was disinterest in cerebral palsy. Physicians in general preferred to treat children for whom the prognosis was considerably more favorable. Through continuing demonstration of new and improved techniques, we were eventually able to overcome to a great extent this initial medical disinterest in cerebral palsy, with the result that the physicians formed the American Academy for Cerebral Palsy.

Therapists were discovered who had sufficient dedication to their fellowmen that a dramatic recovery was not the most essential requirement for satisfaction in their work, and the concerted effort on behalf of such severely handicapped persons as those with cerebral palsy was under way.

The story of rehabilitation is a dramatic one in the results that are often achieved and the

happiness and fulfillment brought to many. The variety of cases in a comprehensive rehabilitation center is appealing to many workers. There is variety in rehabilitation settings too. Workers who a few years ago might have looked forward to working mostly in hospitals now have a smorgasbord to choose from—hospitals, rehabilitation centers, special education schools, home care programs (which are returning to the scene), mobile services, and many others. There are openings in teeming metropolitan cities—in mountainous, sparsely populated states—and in Latin American countries such as Guatemala—a really new frontier!

In presenting the story of rehabilitation to those making a choice of careers, a concerted program is needed. It should be the primary target of the Indiana Commission for the Handicapped. Through careful planning and the utilization of every available avenue in your communities, some real progress should be recorded in the year ahead.

Health Career Clubs can be organized; health fairs stimulated, as an excellent basis for recruitment. "Career days" in community high schools can be effective, but they are all too often spasmodic occasions, haphazardly planned and not well attended. A higher priority seems to be given to football rallies, athletic banquets, senior proms, than to the much more significant task of choosing one's vocation wisely. To help overcome this apathy in our communities, perhaps some incentive plan might be developed through which awards would be given to schools which most effectively present the challenge and the opportunity of health careers to their students.

The vigorous but careful use of mass media can be effective in recruitment—newspaper and magazine articles; radio and television discussions, panels, interviews. Films on specific careers and disabling conditions are widely available, as are books and pamphlets. The National Committee for Research in Neurological Disorders, for example, has recently prepared an excellent pamphlet entitled "Exploring the Brain of Man," which highlights dramatically the challenges in this field of interest.

There are numerous resources which will provide interested groups and individuals with a vast amount and variety of materials. Among them are the National Health Council, which has established a Commission on Health Careers to further interest in one of its primary concerns, the availability of health personnel; voluntary agencies and government agencies, who are rapidly expanding their programs and are faced with this daily dilemma of a shortage of trained workers. Your Indiana Society for Crippled Children, among others, can provide information on scholarship programs, library and film services, employment registry services, and other recruitment aids.

In your personnel recruitment activities, it is well to keep in mind some of the basic factors identified by Schofield which lead an individual into the selection of a career: 1) Family tradition and parental pressures; 2) Social prestige of a vocation; 3) Promise of economic return; 4) Particular demand for personnel; 5) Personal interests, values and motives; 6) Development of strong identification.

Students in one study gave these additional specific reasons for selecting careers in rehabilitation: 1) A desire to work with people; 2) A wish to be useful and needed; 3) Hope for some recognition; 4) Desire to learn; intellectual stimulation; 5) The challenge of rehabilitation; 6) Opportunity for accomplishments at an early stage (as contrasted with the long-term goals of research); 7) Availability of information regarding the range and nature of career possibilities within a large professional field.

Unfortunately, and for reasons not clearly understood, health and rehabilitation facilities utilize all too little of a precious resource—the volunteer—one "who enters into, or offers himself, for any service of his own free will." America was founded by volunteers. Voluntaryism—which parallels democracy—is more clearly identified with America than with any other existing nation. We all need to recognize the tremendous manpower potential of volunteers. We must be more cognizant that volunteers, properly mobilized by skillfully trained staff and leadership, give an organization strong roots from which it can grow and from which can spring financial support, and avenues through which understanding can penetrate and public opinion permeate. In volunteers we have leaders and followers, dreamers and doers.

A vivid example of the effective utilization of volunteers was the Eighth World Congress of the International Society for the Rehabilitation of the Disabled, held in New York City. More than

1,000 volunteers served on working committees during three years of intensive planning, and the 4,000 persons present from more than 70 countries gave eloquent testimony of the success of their efforts. In addition, a corps of 150 Boy Scouts served throughout the Congress as messengers and special aides. These young people were exposed to rehabilitation in a glamorous setting, where recognized authorities who exemplified dedication and leadership were in plentiful supply, and where the challenge of service to others reigned supreme. Of this group of boys, six have identified medicine as a chosen career; four others have asked their advisors about a career in education for the handicapped; and more than a dozen have begun personal savings to help them toward careers in rehabilitation.

Thus, a meeting dedicated to the furthering of "Rehabilitation and World Peace," had as a valuable by-product the recruitment of needed workers. Any meeting on rehabilitation can likewise become a valuable recruitment tool.

Americans finally became aware of the critical situation in education, and realized that no nation can maintain leadership in any area of endeavor without a strong program of education. The chains of apathy were finally broken, and now teachers' salaries, working conditions, and general status are receiving attention, as well they should. Will the associated health professions awaken to the problem which faces them in rehabilitation? The opportunity is here—the time is today—the blueprint is yours—and the results will be a stronger and happier America.

As Dr. Schweitzer so wisely has said, in words that might have been meant for us, "The world needs not for new organizations or new movements, but for the personal influence of more people who will really show concern."

Following is the text of an address given by Andrew C. Offutt, M.D., Indiana State Health Commissioner.

"Let George Do It"

The development of a theme on rehabilitation and why it is turned over to "George" is not very difficult. The magnitude of the problem involved is such that time limitations cause one to wonder how best to tell the story. It is not difficult to understand that our mission is clear, and I should like to spend a good part of my time, in these remarks, outlining the problem and an approach which will tell you why "George" will fail.

Since the dawn of history, mankind has been placed in a situation where, when certain of society's members become disabled the problem could not be ignored. During World War II a comprehensive concept of rehabilitation was developed which would "restore the handicapped person to the fullest physical, mental, social, vocational, and economic usefulness of which he is capable." In the aboriginal society the care of the afflicted members of the tribe or clan was a relatively simple matter. They were simply buried in the ground up to their neck until nature took its toll, or they were driven out with either the simplest of weapons, or no weapons at all until their inability to survive cared for the problem. I say to you, then, that the study and development of rehabilitation facilities are marks of civilization. It stands as a guidepost and a marker to those who come after and to ourselves of the point in our development which we have reached.

In the past 15 years we have seen a rather tremendous advancement in all phases of rehabilitation. We have come to realize that the benefits available from restoring a disabled person to his full productive capacity will far outweigh the cost of maintaining that same person in idleness. The advances that we have seen have arisen from cooperation of institutions, professions, organizations, and, yes, the individual himself, in providing a complete and effective rehabilitation program.

In speaking of this cooperation it should be pointed out that a successful rehabilitation program must be built upon the interrelationship between medical, social, vocational, and economic efforts. The medical aspects of rehabilitation are designed to enable the disabled person to meet all the physical demands made by daily living. Medical service should provide accurate diagnosis; hospital care and treatment; psychiatric services; physical, occupational, recreational, and speech therapies. It should concern itself with remedial physical training and the provision of prosthetics. Cooperating with medical services are vocational and employment rehabilitation

services, which include evaluation and testing of capacities as well as training either in school or on the job. Guidance during training and after placement is essential if the value of the services provided are to be retained. Economic processes cannot be ignored. The need for financial security while rehabilitation is going on and during any adjustment period may require that the individual's family have help. Therefore, the necessary social welfare services will need to be available as required.

It is obviously true that a rehabilitant may not require the whole battery of the services available since the needs of each person vary and the rehabilitation process is nothing if it is not an intensely personal matter which must be adapted to the particular patient's needs. The failure to meet any requirement may result in a failure of the entire process. In planning rehabilitation certain fundamentals are essential. Coordination of effort is necessary between different services, financing must be assured, building facilities available, and equipment and a trained staff provided. It goes without saying that the case of every handicapped person must be considered individually, and this individualized attention will be necessary throughout his entire program of rehabilitation.

We estimate that 125,000 disabled persons throughout the United States are being rehabilitated each year. However good this accomplishment seems, our rehabilitation effort is still falling far short of the requirement for it. Our citizens are being disabled at more than twice the rate at which we are rehabilitating them. In addition, the program scarcely ever reaches those who are in the greatest need of its services—the severely disabled.

In too many cases the disabled person has found that his condition reduces him to dependency and helplessness. In many cases he has been able to avail himself of some services and to need others which are unavailable with a net result that the success of the rehabilitation procedure was doomed to partial success or even failure. How useless it seems if a disabled person is medically restored but lacks training for the employment for which he is physically capable. His rehabilitation woud enable him to function as an active and independent member of society. Without these things he is incapable of solving domestic and income problems and his rehabilitation may be of no avail and he may revert to his former condition.

In taking first things first in any rehabilitation program, a general medical report is necessary to determine the physical condition of the client, the limitations of his disability, and the probable outcome of the rehabilitation program. For instance, a hearing disability may require an examination to determine the extent of hearing loss and the feasibility of using a hearing aid. A mental disorder would require an examination by a psychiatrist. The type of disability, its severity, and the effect on employability are important factors to consider in helping the applicant select a suitable vocation.

Vocational counseling should be emphasized as probably being the greatest service rendered to all rehabilitants. It is the one basic element in every individual plan. It is the service that is a continuous part of the whole rehabilitation process. Early in the rehabilitation process the major effort is medical. Before the rehabilitant has completed the project, medical treatment and care has, to all intents and purposes, been reduced in importance until it drops out of the picture. Upon vocational counseling depends the selection of an appropriate objective based upon the client's assets and liabilities. The counseling will endeavor to make the fullest use of the handicapped person's potentialities and, at the same time, make every effort to minimize his limitations.

Where medical advice indicates that the disability is stable and may be reduced or removed in a reasonable period of time, a program of physical restoration may be instituted. Physical restoration may be medical treatment, surgery, hospitalization, physical and occupational therapy, and the provision of artificial appliances. It is with consideration that I put artificial appliances last since I am afraid that at first blush many of us think of physical restoration as simply being that process which provides a prosthesis in those cases where required.

When the capacity and the interest of the handicapped individual indicate that he is ready to profit from a program of vocational training, then a program of this type should immediately be arranged. A training program may require supplies, placement equipment, transportation to the training facility, and, perhaps, even maintenance while the training process is going on. The requirements of the program depend entirely on

the particular needs of the individual being trained.

And now at last we come to the final step in the rehabilitation process. This is, to the individual, many times the most important step of all because it recognizes the victory over a long-standing handicap. This step of victory is entry into employment, and no rehabilitation program is complete until this ultimate goal is reached. And I should like to add here that while for some this goal will not be possible these, too, should have the benefit of the program insofar as they are able to pursue it. Entries into employment may be made by dealing directly with employers, but I think more usual is the assistance of employment services, placement agencies with training facilities, former employers, and just interested people. There are, of course, those instances in which the trainee secures his own job. The rehabilitant should be kept in touch in a follow-up period until he has successfully adjusted to his new job.

I cannot emphasize the next point enough. Placement should always be on a business basis. The handicapped expect no "made work." The handicapped want to be hired on the basis of merit. The handicapped want to work and to produce to the satisfaction of the employer. The handicapped man or woman wants to feel reasonably secure and to have a useful part in his community life.

Employers hire individuals for their ability to produce a product on the job. The results produced on any job are based upon several things, such as the worker's fitness for a particular job; the worker's reliability; the worker's interest in the job; careful workmanship; and, in some jobs, such things as versatility and personality.

It is then obvious that every individual may have certain handicaps for specific jobs and whether he be physically disabled or not it is necessary to match ability to the job at hand. That is, physically impaired persons are no more handicapped for jobs that they are qualified to do than are able-bodied persons.

It is estimated today that about ten per cent of the men and women in our civilian labor force have physical handicaps. This means that, nationally, there are approximately something in excess of six millions in our labor force who are going to their job every day in the face of a physical handicap.

In addition to the millions of known handicapped workers, there are large numbers of others with physical impairments who are not yet ready for work either because they have not completed, or, sadly enough, begun the rehabilitation needed to fit them for gainful employment. It is estimated that there are at least one and a half million workers with handicaps who are outside the labor force today. This group would enter the labor market in search of jobs if they had received the necessary vocational rehabilitation and training.

I have previously said that we are disabling our people at a rate twice that in which we are rehabilitating them. Each year we increase by thousands those who are disabled by accidents and disease. If you are interested in thinking of this matter in terms of money alone, the cost to the state cannot be measured in terms of money or production. There is also the effect on the individual himself, his family, and his community. A prosperous society needs the participation and productive efforts of as many of its citizens as is possible.

Rehabilitation is an important and vital thing to every one of us, and it is no "crumb-from-the-table" operation. The cost of rehabilitation of an individual is far less than the cost of his maintenance as a nonproductive member of society. This program is not a luxury, since we must remember that this nation suffers an economic loss of more than ten billions of dollars each year because disabled men and women are away from their jobs. To put that in a more positive vein, every dollar spent for rehabilitation brings back ten dollars in the production of a worker who is back on a job that he can do and do well.

Everyone who is engaged in providing for the welfare of human beings, whether he is aware of it or not, has a queer and unavoidable responsibility for making others understand what he is trying to do. He also cannot avoid the responsibility of explaining to others why he is trying to do it. We live today in a world of mills and factories and crowded cities. Today there are millions of aged, blind, and sick who are not earning, even in these times, enough to meet the cost of rent, food, utilities, and clothing. We are apt to think and talk of how any man can "make a living," and that only the worthless, shiftless, and lazy will accept aid.

The security of most American families lies no longer in the land and what it will grow. In Indiana we have moved from a state largely agri-

cultural in economy to one of the foremost industrial states of the nation. Our people cannot turn to a beneficient free land for the money and wages which will alone obtain essential food, clothing, and shelter. Our economy now rests on the unstable and unpredictable opportunities that we have to get and to hold a job. The average individual, when stricken by illness or injury, can no longer turn to his savings or to his family or children to see him through a long illness and rehabilitation. Few families have the extra room or the extra cash which would enable them to aid the ailing one to get back on his feet through the long period that this process would take. I admonish you to look among your friends. At the turn of the century such an examination would have revealed to you that most of your friends lived in large houses with adequate room in which an ailing member of the family could be kept for a rather indefinite period of time. The situation has changed materially. We look now for smaller homes with greater utility and homes which provide the space which we and our family need today.

When you talk to your friends you are face to face with the necessity of making not only the "well-informed," but those "willing to learn," understand the facts of life as they are in our society today. You must make them understand the things that can be done in rehabilitation; but, even first, you must make them realize how small and helpless are these individuals in our complex world.

In summary, the restoration of the handicapped to the fullest physical, mental, social, vocational, and economic usefulness of which they are capable, involves four definite steps:

1. A complete diagnosis—the starting point of such a diagnosis is medical evaluation of the patient with a goal of maximum useful activity in mind. This requires, as a minimum, a general medical examination, and, if necessary, specialists' examinations. It will reveal both the patient's limitations as well as his possibilities for improvement. Psychological, vocational, educational, and sociological factors are evaluated to complete the pattern which the individual program of rehabilitation will assume. Based upon these findings, a plan is developed to achieve a total rehabilitation.

2. Physical restoration—here, hospitalization and surgery, physical and occupational therapy, prosthetic devices (braces) and speech training are utilized to enable the patient to reach his maximum physical efficiency.

3. Vocational training—this may be carried on concurrently with physical restoration or certainly as soon thereafter as is practicable. The rehabilitant who has a saleable skill is in a position to minimize the handicapping effect of the disability, and will find himself in a favorable position to compete with the nonhandicapped for jobs.

4. Selective placement and follow-up—the rehabilitation program is not finished until the client is working satisfactorily on a job. This is a job that is suited to his capabilities and in which he can work without danger to himself or to others. This goal was achieved through an individualized placement program which matches the known capacities of the applicant to the specific requirement of the job. The placement process extends the necessary follow-up to insure acceptance of the situation by both employer and employee.

This concept of rehabilitation takes the patient from the bed to a job. It states exactly the philosophy underlying the programs of official and voluntary rehabilitation agencies.

In conclusion, we may say that:

1. Rehabilitating the handicapped is not only the most humane but the most economical solution that we have at hand. The price of maintaining the handicapped person for one year is often greater than the total cost of his rehabilitation program. A single, nonrecurring expenditure may thus obviate years and years of welfare or family support.

2. Our present rehabilitation efforts are only scratching the surface. There are large groups of people who are scarcely being reached. Think with me of the cerebral palsied, the speech defectives, the mentally ill and mentally deficient, the cardiacs, and the severely disabled from whatever cause.

3. Rehabilitation is not free. Rehabilitation cannot be financed on a "crumbs-from-the-table" basis. If we are to meet our problems we must have a major increase in funds, facilities, and trained personnel. If we are to meet the demands made upon us we must develop common goals, we must eliminate duplication, we must have a free interchange of services; and, given all of these things, our present resources will go much further than today.

Finally, in considering rehabilitation many people think that we are dealing primarily with material things. We are teaching somebody to

make something; we are teaching somebody to do a new type of job. I should like to say to you that this is not the case. We are dealing with people, people who think, people who live, people who have emotion, and we are dealing with the heart of a man. I find in St. Matthew 25:40, these words which I would like to leave with you in closing: "Inasmuch as ye have done it unto the least of these my brethren, ye have done it unto Me." Nowhere can I find the injunction to let "George" do it—everyone knows that "George" can't do it.

Following is a summary of an address given by Miss Mary E. Switzer, Director of the Office of Vocational Rehabilitation.

"Serving the Handicapped at Home and Abroad"

The state-federal partnership effort to restore disabled people to production work and satisfying life is booming, and Indiana is launching a new movement to catch up with the national pace.

Two highly encouraging signs of increased activity and productivity in Indiana's program for vocational rehabilitation are here before us today. Most encouraging is the vital interest that Governor Welsh is taking in the problem of disability and its inseparable companion, dependency. The other is the recent action of the legislature in increasing the appropriation for rehabilitation by 32 percent over last year.

All of us who are interested in rehabilitation hope that the appropriation of $363,000 for each of the next two years will mean continuing progress in Indiana. In the past this appropriation has been augmented by other funds and there will be a need for a continuation of that policy if the substantial progress that we anticipate is to materialize.

The cost of disability is mounting and this cost has to be paid for in one way or another. Rehabilitation . . . the removal of the cause of the burden . . . is the most logical and least expensive procedure in the long run.

Last year our nation's public assistance bill attributable to disability was about $800 million, not counting the payments to the needy aged. Against that, we are spending, in federal and state funds, slightly more than $100 million for rehabilitation. We can eliminate some of that continuing dependency by spending more money on rehabilitation—a one-time cost instead of a year-in-year-out burden.

Indiana's public assistance burden on account of disability may run as high as $7 million a year, including $4 million a year for aid to the blind and aid to dependent children of disabled parents, plus one-third of the cost of general assistance . . . payable from state and local funds only . . . or $3 million due to handicapping conditions.

In the effort to gain adequate financing and adequate progress for vocational rehabilitation, President Kennedy is giving strong support. In asking for a substantial increase in our appropriation, the President gave us this assurance:

"This administration intends to see that the rehabilitation of disabled Americans and their return to active and useful lives is expanded as rapidly as possible. Our federal-state program of vocational rehabilitation and the cooperating voluntary agencies must be assisted in providing more nearly adequate facilities and services to reach the thousands of persons who become disabled every year. We need their talents and skills if our economy is to reach a high level of performance. To this end I shall recommend to Congress an increase in federal matching funds to expand the vocational rehabilitation program."

Not only the President but Secretary Abraham Ribicoff of the Department of Health, Education, and Welfare is giving solid backing to progress.

We have set a goal of 200,000 rehabilitations a year and Mr. Ribicoff has endorsed that as realistic and attainable. Last year, 88,300 disabled men and women were returned to useful life and near normal activity through the states' programs. That was a new record for the fifth consecutive year and is an indication of how we can progress, now that we have a full program of training professional workers who have been in short supply, a full program of building and expanding rehabilitation centers and a truly thrilling program of research into new and better ways of effecting rehabilitations.

Another great indication of how fast we can increase our effectiveness is that in the past decade

we rehabilitated about 700,000 disabled people and that was 100,000 more than had been rehabilitated in the previous 30 years of the program's existence.

The economic values of the program are so great as to make it extremely costly for the states not to advance their rehabilitation rate.

Nearly 18,000 of the 88,300 who were rehabilitated during the last year were removed from public assistance rolls, at an estimated savings of $17 million a year, by a one-time expenditure of $16 million for their rehabilitation.

About 68,000 of the total were unemployed when they entered the rehabilitation process and about one-fourth had never been able to work. Those who did have employment were earning at the rate of about $61 million a year, generally in unsafe jobs. In their first full year of employment, the entire group is earning at the rate of about $171 million and will pay federal income taxes of at least seven dollars, during their working lives, for each federal dollar spent for their conversion to employment.

These are the economic facts of life in vocational rehabilitation and we have full faith that Indiana will rise to its responsibilities in extending full opportunity to its disabled.

Practically every state has increased its tempo and its support of rehabilitation since a new law to expand and increase results was enacted in 1954. In that fiscal year, the federal government invested about $23 million and the states about $13 million, whereas the 1962 budget calls for federal expenditures of more than $80 million and state contributions of about $40 million.

A steady increase in funds is essential to providing the tools to help the states and the voluntary groups to increase their effectiveness through rehabilitation centers, workshops, more trained people, and a program of research and demonstration.

Several special demonstrations are being operated in Indiana. There is an occupational training center for the mentally retarded in Muncie. A similar center is operated for the emotionally disturbed in Evansville. The Medical Center of Indiana University at Indianapolis operates a visual aids clinic, where persons with sight difficulties that hamper their employment opportunities are fitted with devices to correct their vision. And at Purdue there is research into problems relating to vocational potentialities of the blind.

An additional project in Indiana of which we are extremely proud is being conducted by the Goodwill Industries in Indianapolis. It is a work adjustment program for disabled persons with emotional problems. Paul A. Schmidt, a muscular dystrophy victim in a wheel chair, is the director and it was my pleasure to greet him in my office last week just before he received an award as the Goodwill Worker of the Year—a nationwide honor.

This project was approved for three years of support and has proved so successful that it was extended for a fourth year. During the first three years, Mr. Schmidt and his associates—a physician, a psychiatrist, a psychologist, a nurse and a social worker—worked with 130 emotionally disturbed people who also had complicating physical handicaps. The result was that 86 of them were helped enough to take employment and succeed in their work. This is excellent, considering the difficult types of cases handled. We hope that equally good results will come from this year's work.

The training program for rehabilitation workers is reaching new proportions each year. About $7.5 million has been granted during the fiscal year to educational institutions over the country for support of curricula in rehabilitation subjects to relieve the severe shortage in personnel. Indiana University has received more than $30,000 for teaching and training in occupational therapy and speech pathology and Purdue has received about $27,000 in grants supporting curricula in several subjects.

One of the salient elements of the national upsurge in rehabilitation is the establishment of new centers and workshops. More communities and states are coming to realize that if the work potentialities of disabled people are to be evaluated and put to use, there is the absolute need for the proper setting and equipment, and there is a steady rise in the creation and addition to these facilities. Many of them are built through the joint efforts of community groups, and the federal government embodied in Hill-Burton hospital construction funds. Well over half a million dollars in federal money has gone to aid the construction of such institutions as the Evansville rehabilitation center, rehabilitation facilities in hospitals in Indianapolis and Gary, and Indiana University at Indianapolis.

With reference to research in other countries, we have always cooperated and practiced reciproc-

ity with other nations in the exchange of useful and beneficial information in rehabilitation. And we are happy to see that there is a swelling tide in many countries to participate in research that is bent toward their national needs, but nevertheless contributing to the world's store of knowledge.

So compelling is the need for research in its international aspects that the Congress was asked last year for a share of the counterpart funds that have built up in certain countries from our sales of surplus food. We were granted $930,000 in these funds. Soon after, three representatives of the Office of Vocational Rehabilitation visited countries in Europe and Asia to confer with health officials of Israel, Pakistan, India, Poland, Burma, UAR-Egypt, Indonesia, and Yugoslavia. Another went to Brazil. To the end of March, thirty proposals for research projects had been received by the Office of Vocational Rehabilitation—20 from Israel, 5 from India, 5 from Brazil—and many more are anticipated from these and other countries.

There are many proposals to increase the flow and exchange of international knowledge about rehabilitation. When more of the counterpart-funded projects are in operation, perhaps we shall get an adequate clearinghouse to coordinate and disseminate all of the new knowledge that becomes available, so that disabled people all over the word shall have freer access to the growing volume of rehabilitation knowledge.

The size of our own problem is growing because a new set of problems has been added. Your state agency, along with the rest of us working for the disabled, is faced with the growing urgency of rehabilitation measures for the aged. The dimensions of rehabilitation have been enlarged by the growing number of older citizens in need of services, for the medical aspects, employment opportunities and reduction of dependency among them are matters that require an approach all to themselves. I wish for the new regime in Indiana serious consideration of these problems and success in meeting them.

DISCUSSION SESSION REPORTS

Discussion Session Reports

First Discussion Session

Topic: Discussion of present personnel shortages and the consideration of recommendations for a coordinated attack on this problem.

Medical and Dental

Discussion leader: Morris Green, M.D.

Recorder: Ralph McDonald, D.D.S.

The discussion session was attended by representatives of medicine, dentistry, physical therapy, occupational therapy, nursing, and nutrition.

Summary and recommendations:

1. There is an acute shortage of personnel in all of the disciplines represented at the session and there appears to be no immediate solution to the problem.
2. It would be helpful to obtain statistics on the current and projected shortages in the various fields.
3. The problem of continuing education needs more emphasis so we can keep up with the progress in the various fields.
4. There is a need to increase communication between the various groups.
5. Similar meetings should be held on a county or regional level to stimulate efforts toward recruitment and better utilization of available personnel.
6. Steps taken to improve recruitment should include acquainting high school and college students with opportunities in the field of rehabilitation. This could be an educational function of the Commission.
7. There is a need for scholarships, fellowships and grants to attract and support individuals during their training programs.
8. Many participants expressed a desire to have the Commission solicit written comments from those representatives attending this conference. This recommendation was based on the thought that there was insufficient time to discuss the problems adequately during this session. Also the conference may stimulate additional comments during the following weeks.

Social Workers

Discussion leader: Patricia Beall

Recorder: Marion Warner

Seventeen persons attended the discussion group of social workers. They represented a variety of settings and agencies and had a variety of training and experience in the field. The group discussed the various problems related to personnel shortage, recruitment and training at considerable length. There was consideration of the fact that all social workers do rehabilitation work in so far as they help people to help themselves toward a more adequate social functioning though the social workers may not be in a rehabilitation setting *per se*. It was the consensus of the group that there was a serious shortage of social workers in the state. Many social workers have not had any formal training in the field but have had to learn on the job. To assist in the recruitment and training of social workers to meet existing shortages, the group made the following recommendations:

1. Efforts should be made to interpret more broadly the field of social work and rehabilitation to young people at the high school level. Many high school students do not know about the profession nor do their high school counselors. To further recruitment for the profession it is recommended the Commission consider support of a Careers for Social Work Program which is currently being considered by the social work profession to stimulate, coordinate and implement recruitment of young people to the field of social work in Indiana.
2. In order to provide further training for social workers in the field, it is recommended that consideration be given to planning regional in-service training institutes by a rehabilitation team representing all disciplines for social workers and other interested professions throughout the state.
3. In order to provide professional graduate school training of social workers, there should be consideration given to the establishment of additional scholar-

ships for professional training for social workers.

4. It was noted that one of the professions not represented on the Commission for the Handicapped was that of social work. Since rehabilitation is a team process requiring the skills of many professions it is recommended that the social work profession be represented on the Commission. This representative should be from the professional association which is the National Association of Social Workers.
5. A pamphlet should be prepared by the Commission to be available in schools, libraries, etc., concerning the training and skills required in each of the appropriate professions and what they contribute in the rehabilitation program.

Educators

Discussion leader: Kenneth N. Orr
Recorder: Mrs. E. F. Ortmeyer

A unanimity of interest with a great variance in areas of responsibility was represented at the Educators' Discussion Session on the situation regarding rehabilitation personnel in Indiana. The group was led by Kenneth N. Orr, assistant professor of the Department of Special Education, Indiana State College, Terre Haute, Indiana. Among the group were university and college professors in the field of special education, secondary public school administrative staff members and boards of school trustees, interested parents, administrators of the state schools for the deaf and the retarded, undergraduate and graduate students in state universities, the staff of private schools for the retarded, members of the State Board of Health, state hospital administrators, etc.

Subjects most closely scrutinized were the procurement and proper training of qualified personnel, the organization and dissemination of all information pertinent thereto, and studied recommendations to better the existing problem of personnel shortages.

The most widely held general consensus was that a lack of proper channels of communication between state agencies and schools, university and college teacher training centers, graduate and undergraduate students, secondary and junior high school students and their parents is the greatest stumbling block to a most necessary recruitment of trained personnel.

Specific recommendations for immediate action include the following:

1. An improvement in channels of communication between each responsible group.
2. An increase in effective public relations on the entire problem.
3. Organized effort towards recruitment.
4. A well-known central bureau set up for the dissemination of all pertinent information. (Here a recommendation was made that the State Board of Health be referred to more frequently as the ultimate authority on the subject.)
5. A need for increased vocational guidance at the elementary and junior high school level directed toward careers in rehabilitation.
6. A general upgrading of teachers' salaries with career increments for special education instruction.
7. A greater stressing and further development of Health Careers, Incorporated for the recruitment of trained personnel.
8. An enlargement of the team approach in those working at the training level.
9. The encouragement of social agencies to provide the necessary dollars and desire for the proper training and recruitment of personnel.
10. A closer alliance with the Legislature if it means running for office oneself, to enact enabling laws for better training and recruitment in our state.

Recreation Workers

Discussion leader: Janet MacLean, Re.D.
Recorder: Leanah McNeely

We understand that Governor Welsh is in the process of appointing a fifteen-man committee to act as an advisory committee for a recreation director to be employed at state level. We strongly recommend:

1. That members of the committee be appointments actively involved in recreation for physically handicapped and mentally handicapped.
2. That the Commission for the Handicapped try to activate councils and committees for recreation at local level to investigate needs and implement services for the handicapped.

3. That a specialized curriculum be offered in our state universities for preparation of recreation professionals at undergraduate and graduate levels for work with the ill and handicapped.
4. That the Commission make available to high school guidance counselors materials which describe opportunities for recreation professionals in the area of the ill and handicapped.
5. That a closer liaison be established between hospital and community recreation professionals in order to develop more and better programs for the ill and handicapped.

Sheltered Workshop Personnel

Discussion leader: Paul Schmidt

Recorder: Ralph Werking

The following statements and recommendations were the result of the discussion:

1. It was suggested that supervisors in industry have experience which lends itself satisfactorily in the sheltered workshop. The services of a retired industrial supervisor can often be utilized. Recruitment of industrial supervisors into the workshop should be followed up with in-service training geared to the needs of the workshop. Other staff specialists such as the counselor can offer much to this training program, if they are available.
2. It is also possible through a system of upgrading within the sheltered workshop to recruit supervisors from the ranks of the workers. Training specialists from local industry and the American Society of Training Directors, Indiana Chapter, are interested in improving the quality of training and the competence of trainers. Their services can be obtained on a voluntary basis to assist in designing and administering supervisory training programs, by which supervisory workshop recruits can be further developed.
3. The Indiana Employment Security Division and the Division of Vocational Rehabilitation are both possible sources of referral of workshop personnel.
4. At present there are no statistics to show the exact need for such personnel.
5. An extensive public relations program should be launched to educate the public concerning the need for qualified workshop supervisors.
6. Information should be prepared and distributed to local school counselors in order that they might inform young people of the opportunities in the field.
7. It was recommended that standards for a training program for sheltered workshop supervisors be developed.
8. It was recommended that more time be allotted to discussion groups at the next Conference on the Handicapped.

Psychologists

Discussion leader: Gordon Barrows, Ph.D.

Recorder: Mrs. Arthur Kocher

There is an acute shortage of fully qualified psychologists in all service areas. Therefore, we make the following recommendations:

1. Full utilization is not being made of available trained psychological personnel. We suggest that many agencies might employ, on a part-time or consulting basis, individuals now employed by colleges, universities, state hospitals, schools for the retarded, and in private industry.
2. Many of the psychologists trained in Indiana do not remain here because of non-competitive salary schedules in public agencies. We recommend that corrective action be taken.
3. There were some complaints that most psychologists have had little experience working with the severely disabled physically since internships are typically in mental hospitals or clinics. We have two recommendations:
   a. That rehabilitation centers and agencies offer intership stipends to graduate students.
   b. That a survey be made of existing rehabilitation agencies to determine the specific skills and techniques required of the psychologist for successful performance of duties. The information to be utilized by training psychologists planning to work in the rehabilitation area.
4. Agencies sometimes employ inadequately trained psychologists because of lack of familiarity with standards. When there is doubt about an applicant's qualifica-

tions, we recommend seeking the assistance of the state organization for professional psychologists.

5. We recommend that a study be made to determine the long-term staffing needs of rehabilitation agencies in all professional categories and this information be used to establish patterns of recruitment and training.

Speech and Hearing Pathologists

Discussion leader: Robert Milisen, Ph.D.

Recorder: Jean Anderson

The need for speech and hearing therapists has been established by an earlier speaker. This need has several facets in the State of Indiana.

1. Many of the therapists trained in Indiana take jobs in other states. Perhaps we need to investigate the reason for this.
2. More men need to be interested in speech and hearing since they tend to remain in the field for longer periods of time.
3. There is urgent need for recruitment and training in the areas of the deaf and the severely hearing-handicapped.
4. The great need at the present time in Indiana is in the public schools, where at least 200 therapists would be needed to serve 5 percent of the total school population.

At the present time recruitment is being carried on by individual therapists who are working in clinics and schools. In addition, Indiana and Purdue universities have been conducting short-term summer workshops for high school juniors and seniors to interest them in the field of speech and hearing. These projects are sponsored by Psi Iota Xi sorority and have been most successful. However, both schools have been unable to enroll more than a small portion of the total applicants. What do we need in the State of Indiana?

1. Scholarships, particularly at the undergraduate and precollege level.
2. Materials (films, pamphlets, etc.) to be used by speech and hearing personnel already working in the field.
3. A plan for getting information to guidance directors and other high school personnel.
4. Encouragement to the therapists in the field to assume responsibility for recruitment through talks and demonstrations for civic organizations and through personal contact with high school students.
5. Perhaps the teaching of courses in the university extension centers would stimulate interest in the undergraduate student.
6. Parents of speech and/or hearing handicapped children might be utilized to sell the program.

Specific suggestions for an immediate plan of action in recruitment are:

1. Preparation and distribution of a good recruitment pamphlet.
2. Explore the possibilities of a film.
3. Establish a speakers bureau of people working in the field.
4. Support for better working conditions and salaries for speech and hearing therapists in order to make the profession more attractive.
5. The Commission must help to encourage financial support for pre-college scholarships in order to acquaint prospective high school juniors and seniors with a comparatively unknown profession. Furthermore, scholarships for the four undergraduate colleges are badly needed in helping good students who are financially unable to go to college or who wish to choose this profession as their vocation.

Vocational Rehabilitation Counselors

Discussion leader: Freeman D. Ketron

Recorders: H. Allan Heuss
Jack Oathout

The preliminary discussions attempted to clarify definitions of two terms beings discussed; defining just who could be classified as a handicapped person and a description of a rehabilitation counselor and what he did. The remainder of the preliminary period was devoted to four broad areas for consideration by the group.

A. While it was not deemed possible to propose a definition of the handicapped person satisfying to all groups, the handicapped person was defined as an individual with a disability that prevents him from entering into, or continuing in, gainful employment.

B. The rehabilitation counselor was described as a person who deals with disabled persons to help them realize greater utilization of potential abilities and to realize more

effective living, socially, economically, and spiritually.

C. Factors and causes for shortages of competent, dedicated vocational rehabilitation counselors were discussed and enumerated as being:

1. High standards for entry into the field.
2. Low salaries.
3. Poor working conditions.
4. Restriction in advancements.
5. Inadequate provisions for professional growth.
6. Conditions which do not promote self-respect and high morale.
7. Residency requirements which preclude employment of personnel from other states.

D. It was generally agreed that standards of employment should be raised so that higher levels of efficiency and production can be obtained.

E. Standards of training should be reviewed to provide additional assurance that our disabled persons in Indiana are serviced by professional, qualified and competent counselors.

F. In a discussion of salaries it was agreed that an adequate schedule, in line with that of other states, should be established to apply to all of the various classifications of counselors, as well as to other staff engaged in the rehabilitation process.

Positive Recommendations Made By The Group:

A. That the Commission implement and pursue with all possible speed, a program of public relations aimed at educating the general public and employers concerning the need for their help and cooperation in the placement of the disabled.

B. That plans be drawn which will increase the interest of local communities in organizing committees or advisory groups for the purpose of promoting and engineering the employment of the disabled.

C. That additional professional workers be employed so that more of our disabled may receive assistance and to alleviate apparent shortages in the field.

D. That standards for training and employment of professional workers in the field of rehabilitation be reviewed by the Commission.

E. That an adequate salary schedule be established, comparable to other states with like programs.

Administrators

Discussion leader: Spiro Mitsos, Ph.D.

There were eighteen individuals present at this particular workshop session. They represented administrators of a variety of public and private health agencies and organizations. Also represented were some lay leaders. Major focus of the discussion was on the role of the administrator about which there was significant lack of clarity. It seemed generally agreed that there is a distinction between a departmental administrator and a general agency manager. These roles correspond roughly to managerial and administrative roles in any industrial organization.

It was further agreed that there is a shortage of people prepared for administrative roles in health services. Numerous voluntary health organizations and agencies are searching for administrative talent at the present time. This naturally led to discussion regarding who becomes the administrator. In the health field, should we look to the professional disciplines for our administrative talent or to laymen? Are administrative skills to be considered in isolation from professional competence in a specific health field related to the area of handicapped under the individual's administrative aegis? It was generally felt that departmental administrators must be individuals with professional skills. On the other hand, the executive manager of an agency is first and foremost an administrator. Specific knowledge about the problems of the individuals being served and the professional disciplines serving them would be helpful though not a *sine qua non* of the administrator. It was generally felt that the attributes of an administrator in a health service, as administrator, are no different from those of administrators in other kinds of programs.

Recommendations

1. It should be made generally known that there is a shortage of individuals known to be interested in and capable of functioning as administrators and managers in health services.
2. In selection of managerial individuals in health services, we should attempt to promote the concept that administrative

skills and potential being equal, we should look to individuals who also have "related" professional discipline backgrounds.

3. A need for training programs for administrators and potential administrators does exist. The discussion group strongly recommends that the Governor's Commission on the Handicapped undertake as a project the development of training workshops and institutes on a state-wide basis in coordination with the university training programs in administration. These institutes should deal with specific aspects of administrative procedure, should be offered on at least an annual basis and should be open to any administrator of a health service of any professional staff member who might be interested in preparing himself for an administrative role.

Second Discussion Session

Topic: The identification of additional major problem areas in Indiana's rehabilitation effort and the consideration of recommendations for cooperative action toward the general improvement of the total program for the handicapped of the state.

Blindness and Visual Problems

Discussion leader: Durward Hutchinson

Recorder: Glenn Reynolds

Recommendations to the Commission for the Handicapped.

1. We recommend that efforts be directed toward the improvement of communications between agencies serving the blind and families of the blind.
2. It is recommended that all practicing physicians, ophthalmologists, superintendents of schools, heads of welfare departments, optometrists, and special placement officers in state employment offices be furnished with a copy of the Directory of Services for the Handicapped.
3. Recommend that all blind persons be furnished a list of the educational materials and programs available through radio and television.
4. Recommend the compilation of a registry of all visually handicapped persons in Indiana be expedited.
5. Recommend that a study be made directed toward the improvement of library services for the blind in Indiana.
6. Recommend the initiation and encouragement of a program of free eye examinations similar to that being currently sponsored by the Indiana Society for the Prevention of Blindness, such programs to be on a local level under community service organization.
7. Recommend that a conference for the purpose of coordinating all services for the visually handicapped be held at an early date.

Neurological Problems

Discussion leader: Arthur L. Drew, M.D.

Recorder: Carl Fuller, Ph.D.

Forty people representing occupational therapists, physical therapists, special education, vocational counseling, mental retardation, State Department of Public Instruction, nursing, and speech and hearing attended this session.

First question: What are other problem areas involved in neurological rehabilitation? What is there in common which all people having neurological problems share?

1. Lack of understanding.
2. Lack of trained personnel.
3. Poor interpretation of medical findings by physicians to parents.
4. Confusion of interpretations provided by physicians on one hand and special interest groups on the other.

What steps can be taken to solve the problems represented above?

1. Involve the family or referring physician in staffing sessions at special clinics.
2. Insist that physicians supply to other workers the answers to specific questions they raise.
3. Have neurologists on policy making boards of special interest groups.

Do other handicapped groups share these problems? Are there problems peculiar to neurology which are not shared by the other discussion groups?

(Replies generally revert to problems of interdisciplinary and interagency communication.)

How can the Commission for the Handicapped deal with the problems discussed here?

1. Study problems of the handicapped at the community level.
2. Establish channels of communication to and from field workers.
3. Pool efforts of special interest groups for common goals.
4. Have the Commission provide financial support for community "rehabilitation councils."
5. Establish its own professional advisory group.
6. Establish a central fountainhead of knowledge.
7. Sponsor area conferences for discussion of special problems.
8. Recruitment procedures should enlist cooperation of vocational counselors in the colleges.
9. Sponsor diagnostic clinics at community level.
10. Sponsor "rehabilitation fairs" modeled after health fairs in other states.
11. Take an active part in stimulating knowledge in teacher training programs.
12. Sponsor an operating subagency for collection and dissemination of information about rehabilitation.

Orthopedic Conditions

Discussion leader: Carl D. Martz, M.D.

Recorder: Wilma Watt

1. Be it resolved that, in order to help break down barriers, communications between all disciplines in rehabilitation be encouraged, and that professional pride and prejudice be resolved.
2. Be it resolved that a more adequate and generous medical background be provided for all workers in rehabilitation.
3. Be it resolved that our governmental, educational, and religious architecture be designed to provide easy access for handicapped individuals.
4. Be it resolved that our state be dotted with sheltered workshops representing the cooperative efforts and enterprise of all individuals and agencies involved in rehabilitation.
5. Be it resolved that workshops be set up to give progressive experiences in order to move the worker out of the workshop into a position of a living wage.
6. Be it resolved that a consistent effort in public information and education on behalf of our rehabilitation efforts be inaugurated with special consideration being given to the individual character of the disability.

Mental Retardation

Discussion leader: Tony C. Milazzo

Recorder: Audrey B. Russell

I Problems:

1. Community education: Acceptance of the mentally retarded. Work contracts for mentally retarded workers.
2. Bridging the gap between period of school and employment.
3. Follow-up after placement.
4. Lack of funds and proper use of funds already available.
5. Lack of space.

II Solutions:

1. Commission can help educate families, employers, unions, general public, through preparation of materials and can serve as a clearinghouse as to what helps are available on state level.
2. Can make contacts with individual agencies who can help locally.

Speech Problems

Discussion leader: James C. Shanks, Ph.D.

Recorder: Jean Anderson

Recommendations

1. Support efforts to retain personnel in the field and to endorse recommendations for increased improvement in facilities.
2. Encourage personnel to raise their professional standards through workshops and specific short courses.
3. Evaluate and coordinate diagnostic speech services throughout the state.
4. Encourage expansion of speech services to pre- and post-school age groups.
5. Channel information to counselors concerning possible influence of speech disorders on employability.
6. Disseminate information to the public concerning the needs and services avail-

able from the speech and hearing profession.

7. Suggestions relative to future function of the Commission for the Handicapped:
   a. Hold future state conferences as the need arises.
   b. Continue to have the field of speech and hearing represented in future activities of the Commission.
   c. Declare itself willing to report the activities and plans of the Commission to professional speech and hearing meetings.
   d. Consider means of improving direct service to speech and hearing handicapped individuals including stronger state-level agencies.

Deaf and Hard of Hearing

Discussion leader: William J. McClure, Ph.D.

Recorder: Vincent H. Knauf, Ph.D.

Specific Problem Areas, Recommendations and Comments:

1. Adequate psychological services should be made available for the evaluation and counseling of the deaf and hard of hearing children of our state and their parents, by psychologists with a background of experience in this field.
2. A study should be made of the training and educational needs of the children, severely hard of hearing but not deaf, who could benefit from an early and concentrated program emphasizing language and basic communication skills.
3. Provisions should be made to meet the special needs of the deaf and hard of hearing children with multiple handicaps. Examples of the types of children referred to are: the mentally retarded deaf, the physically handicapped deaf, the brain injured deaf, etc.
4. There should be a plan for making the public aware that while deafness is a physical handicap, it is an invisible one, the effects of which are manifested as educational, social and communications problems.
5. Adequate vocational counseling is needed particularly for the hearing handicapped.
6. Adequate and mandatory programs of hearing testing and hearing conservation are needed in all public schools.
7. The colleges and universities of the state should be encouraged to have adequate recruiting and training programs for personnel to work in all phases of the education and rehabilitation of deaf and hard of hearing individuals.
8. There should be personnel within the Department of Public Instruction with the proper training and experience in the various area of exceptionalities to coordinate existing and to direct new programs for the physically handicapped, particularly for the hearing handicapped of the state.

Mental Illness

Discussion leader: John W. Southworth, M.D.

Recorder: Patricia Laurencelle, O.T.R.

Twenty-seven persons attended this meeting representing a wide variety of clinical and agency specialists. A majority of the group participated in the discussion which confined itself largely to the problems surrounding support of the psychiatric patient in some role of normal productive function in the community. Emphasis was given to the fact that maximum communication and involvement between all agencies and services concerned at any point in the patient's care would result in improved service at every point in his care; this involvement should begin as soon as the patient's problem is identified.

Specific recommendations were made as follows:

1. Psychiatric rehabilitation would benefit in Indiana from funds available in support of small demonstration projects at the local level.
2. Psychiatric rehabilitation requires increased efforts in research.
3. Detailed exploration should be made of factors which appear to serve as barriers to interagency cooperation.
4. Interagency and interservice coordination is certainly needed, but it was pointed out that this fact was sometimes used by appropriating bodies to justify reluctance to provide needed funds and resources;

i.e., "you have facilities, you just need to improve their coordination." It was emphasized that lack of coordination was often due to inadequate staffing. It was recommended that an increase in budget for staff and facilities was required in order to provide more and better psychiatric rehabilitation service.

5. It was recommended that interested local lay groups be mobilized to explore and coordinate existing and available local resources.

6. A strong plea was made by the representatives of the state employment service that adequate vocational appraisal be provided by the discharging psychiatric hospital, and made available on request to the state employment service and other appropriate community agencies.

7. It was recommended that greater use be made (and more facilities provided) of halfway house, outpatient, day-or-night hospital services, particularly those emphasizing work conditioning or vocational evaluation programs. It was pointed out that existing outpatient rehabilitation centers which until now have provided only for problems of physical rehabilitation, could be enlarged or adapted to provide this service.

8. It was pointed out that treatment and rehabilitation should be begun as early as possible in the illness, thus in many instances obviating need for institutionalization. An increase in community psychiatric clinics, psychiatric services in general hospitals, day hospitals, etc., was recommended to this end.

9. It was recommended that the medical profession should play a greater role in planning for continuity of patient care throughout the agency spectrum.

10. Finally, it was recommended that:
    A. 1) The Division of Mental Health, 2) The Employment Security Division, 3) The Division of Vocational Rehabilitation should get together and establish ground rules applicable throughout the state for their cooperative function; and that,
    B. The Commission for the Handicapped might serve as the agency to channel this effort.

Chronic Disease

Discussion Leader: H. Glenn Gardiner, M.D.

Recorder: Douglas Leavitt

Problem: Need for facilities for domiciliary care of totally handicapped where skills in care on a continuing basis are required.

Recommendation: That the Commission set about determining the number of the handicapped needing medical and/or domiciliary care as the initial step.

Problem: The care of those who are not totally and completely disabled but whose care requires outside or additional assistance.

Recommendation: That the Commission explore the possibilities of encouraging the formation of senior citizens' group as a means of providing an answer to some of the problems of people with chronic disease.

Problem: Problems of the rehabilitated, employed, chronically ill individual.

Recommendation: That the Commission direct attention to the following problems, all of which are recognizable problem areas for many of those people with chronic disease:

1. Recreation
2. Communication
3. Transportation
4. Architectural barriers in public and private buildings
5. Special medical needs and facilities.

PANEL DISCUSSION

Panel Discussion

TOPIC: *Obstacles to the Employment of the Handicapped in Indiana*
Following are summaries of the remarks made by the panel members.

Edward L. Jewell
Manager, Industrial Relations
Herff Jones Company

In employing handicapped people, we must remember that they do not want more than an opportunity to work. They do not want special attention, nor do they expect unusual concessions to be made in their behalf.

Some employers are reluctant to hire handicapped people because they think those people require a lot of assistance from fellow workers, that they are prone to accidents, and that their appearance is unpleasant to the public. None of these beliefs are entirely correct.

During World War II, as most of you probably know, there was a great shortage of Labor, and many industries bridged this gap by employing the handicapped person to do certain repetitive operations. It was so successful that some employers today actually favor such employees for many operations. The old thinking of some management folks that an employee who has lost a leg or hand, his hearing or eyesight is disqualified for work has been disproved.

I believe the first requirement of industry in relation to handicapped personnel is for top management and supervisory personnel to agree that the handicapped person does have a place in industry. When this has been accomplished, the industrial relations department of the personnel department must then screen all classifications within their shop to determine those jobs a handicapped person could qualify for. The placement unit and medical examiner familiar with the physical requirements of these jobs must then determine the job a particular handicapped person should be able to perform.

You may ask at this point, "What about the job performance under this procedure?" My experience has shown, and other statistics that I have seen show that the physically handicapped, in regards to quality and quantity, were equally as effective as able-bodied workers. Further, absenteeism was less for the handicapped worker, and the length of service was greater than for the able-bodied worker. The physically handicapped can and do work as safely as others.

It must also be pointed out that the handicapped person must require a simplification of job routine and some additional supervisory attention. Workers with disabilities of lower limbs must be supplied work and cannot be readily shifted from job to job as production sometimes requires; and a blind person requires some additional attention.

I am sure my fellow panelist, Mr. Roberts, will concur when I say that all handicapped employees are hired under the same rates as the non-handicapped, and are given merit increases, when earned, the same as the non-handicapped. Some of these classifications are: moulder, inspector, emery, order checker, enamel preparer, bright cut engraver, die and hub cutter, die sinker and hub drawer, pattern maker, ring repair, etc.

In other industries, the following classifications probably could be filled by handicapped personnel: assemblers, filers, punch press operators, sand blast operators, tool repairman, die finishing, drill press operator, etc.

Some of the office classifications that the handicapped could do would be: file clerk, typist, timekeeper, time study man, material control clerk, draftsman, etc.

In conclusion, may I say that our state rehabilitation centers have done a tremendous job in working with the handicapped people. Statistics will show that about 250,000 will become disabled each year throughout the country, so you can readily see the problem they have ahead of them. The rehabilitation centers can restore the disabled person, but we in industry must give him an opportunity and unless he has an opportunity, he has nothing.

The Honorable Governor Matthew Welsh should be commended for calling the First Conference on the Handicapped, and the 1959 General Assembly for creating the Commission for the Handicapped.

I believe we should adopt a slogan for the handicapped person, and perhaps it should read as follows: *"The Handicapped We Can Restore, But We, in Industry, Must Open the Door."*

Jacob R. Roberts, Vice-President
Indiana State AFL-CIO

The problems of the handicapped are of concern to the Indiana State AFL-CIO. We have cooperated fully with the Goodwill Industries and others to make their program a success. To fully utilize the potential efforts of the handicapped in industry, of course, presents many problems.

One problem is the application of workmen's compensation to cover the workers where opportunities are provided for work. This can be alleviated by amending the act that would make possible these workers being covered. At the last General Assembly we proposed to amend the Workmen's Compensation Act to provide the right of a handicapped person, not only handicapped as we visualize them, but those handicapped with pre-existing conditions of heart trouble and other physical disabilities, to state at the time of their employment their defects. Should the worker then become injured, the claim could be adjudicated and paid for through the second injury fund. We failed to pass this legislation.

I wish to bring to your attention an incident that disturbed us very much. A certain corporation in Indianapolis hired almost exclusively handicapped people and was successful in obtaining contracts from several large industrial organizations to perform work operations. The owner of this company then enforced certain impossible rules and regulations that caused the workers to become disturbed. We intervened and successfully helped these people. The Indiana State AFL-CIO does not believe in discriminating or capitalizing upon the efforts of the handicapped people who work in industry.

There are many other problems that can be corrected by a close application of combining the efforts of management, unions, and social agencies to continue the good work of this governor's committee on the hiring of the handicapped, and I want to assure all of you the policy of the Indiana State AFL-CIO is one of cooperation.

Ben F. Small
Associate Dean
Indiana University School of Law

The Indiana Workmen's Compensation Act of 1915 was intended to assure every workman who was killed or disabled in a work accident some reasonably adequate subsistence level for himself and dependents during the period of wage loss. Over the years, as this statute was extended beyond accidents of violent traumatic origin to the more subtle forms of physical debility and aggravated pre-existing diseases, the statute came to cover many cases of wear and tear associated with the aging process. Chief among these were the heart cases. In cases of general circulatory sickness and disorder, with repeated decisions by the Appellate Court of Indiana, only recently checked in part by the State Supreme Court, the cardiovascular accident became almost automatically a work-association incident. These decisions, liberal enough in themselves, have resulted in a general apprehension on the part of most employers concerning the employability of a person whose sickness record shows any predisposition to heart or circulatory disorder. As more people live longer years this means that a great mass of aging humanity is fast becoming unemployable because of the risk of cardiovascular difficulty brought on by age. These persons, though not seriously ill, are nevertheless severely handicapped in their job opportunities. One of the most challenging assignments to which we can address ourselves is the adjustment of this subtle, but very tragic handicap.

Emet C. Talley
Supervisor, Employment Counseling
Indiana Employment Security Division

For many years we have known that there is a great problem in overcoming the lack of understanding among employers about the employability of the disabled and their ability to produce on the job as well as their non-disabled coworkers.

Much progress has been made in the employment of the handicapped. However, the task of finding suitable employment for the handicapped workers is not usually an easy one. The job opportunities for the handicapped depend upon the skills possessed by the individual, the nature of his disability, and the supply of jobs.

Some of the disabilities that present particular difficulty in job placement are epilepsy, heart conditions, mental, amputations, vision, and hernia to name a few.

We have found that large employers are more likely to have high rigid physical requirements or policies that require new workers to start at the bottom on jobs that generally require strenuous

physical effort. More opportunities for employment are found with smaller employers where physical standards are usually lower and hiring policies not so rigid.

One of the persistent fears of employers is that their workmen's compensation insurance rates will go up if they employ handicapped workers. There is still much misconception on this point. However, there is some genuine concern about the risks incurred with hiring older workers with degenerative diseases—heart conditions, for example.

Some employers feel that handicapped workers may not be able to produce as well as the nondisabled and that the handicapped worker may be absent more because of his disability.

Other employers feel certain jobs in their plants should be reserved for their own workers who become handicapped. Such a policy often precludes the hiring of new workers with disabilities.

Much misinformation and prejudice is found in such reasons and in these which are also found: the work is too strenuous; certain types of handicaps are objectionable to the public or to fellow workers; the handicapped are accident prone; disabled workers are absent from work more often; handicapped workers create problems when job transfers are necessary; and handicapped workers have personality problems arising from poor adjustment to their handicaps.

The factual studies made on the work performance records of the handicapped all demonstrate that they produce equally as well as the nonhandicapped; their absenteeism rate is low; and their safety record outstanding.

In spite of their good performance records much misinformation and prejudice still exist creating barriers to the employment of the handicapped. More efforts on the part of all engaged in rehabilitation is needed to overcome these barriers which block or delay the complete rehabilitation of the individual.

MINUTES OF POST-CONFERENCE SESSION

Minutes

"The Utilization of Rehabilitation Centers"

(Post-Conference Session of the Governor's First Conference on the Handicapped)

Presiding: Robert Yoho, H.S.D.
Recorder: Kenneth I. Chapman

In his opening remarks, Dr. Yoho explained the purpose of the meeting as a follow-up of the Regional Workshop on the Utilization of Rehabilitation Centers held at Michigan State University in June, 1960.

Representatives from Indiana attending the Workshop were asked to develop a suggested approach to this problem in their own state and to accept responsibility for stimulating action on the part of responsible individuals and groups.

The Indiana Chapter of the National Rehabilitation Association agreed to sponsor the initial opportunity discussion of the problem which resulted in this meeting.

Dr. Yoho also read excerpts from a recent publication available from the Federal Office of Vocational Rehabilitation. In general it points out that a need has been established for more rehabilitation centers. However, it also recognizes that those centers presently available are not being utilized effectively.

The Michigan State Workshop indicated that the purchaser of service does not understand what services are available from centers and the purveyor of service does not understand what services are being requested by the purchaser. An effort should be made to identify the areas of difference and resolve them.

In the discussion which followed, it was indicated by many in attendance that Indiana faces the utilization problem and it is acute. The centers are concerned about groups not using their services. They do not know why this situation has developed and what changes should be made to interest these groups in using their services.

Other points discussed were related to the quality of services rendered versus the price of services; to what the purchaser and purveyor feel should be offered in the way of services and the budgetary restrictions placed on state agencies which limit their ability to purchase proper services.

A motion was made by Dr. Howard Lytle and seconded by Dr. Spiro Mitsos that the group attending go on record as requesting the State Commission for the Handicapped to take steps to develop an all day conference for the purpose of discussing the problem of the utilization of rehabilitation centers in Indiana. The motion was approved unanimously.

It was further recommended by consent of the group that the conference should be oriented towards resolving the problem in the state as a whole and not towards settling issues between those individuals or groups who have vested interests, and that planning should make sure that the conference permits both purveyors and purchasers an opportunity to express their needs and not allow "indictment" of any one group for its lack of cooperation.

It was also recommended that invitations to the conference go beyond the limited definition of a purchaser and purveyor to include all interested persons.

One suggested point for discussion would be the question of training persons to enter a sheltered workshop as terminal employees.

Awards

The newly formed Indiana Rehabilitation Association was invited by the Commission for the Handicapped to use the occasion of the conference banquet for the purpose of presenting awards and certificates of merit to outstanding persons in the field of rehabilitation in Indiana. This will become an annual activity of the Indiana Rehabilitation Association. Following are the presentations as made by H. Glenn Gardiner, M.D., President of the Association.

Award of Merit

Roy Fenn, Secretary and General Manager of the Tell City Chair Company, Tell City, Indiana.

Mr. Fenn has long been active in civic and community affairs. His contributions to programs of the Boy Scouts, 4-H, crippled children, and others, have reached far beyond the environs of Tell City and the State of Indiana. He is a veteran of World War I; a past commander of Perry County Post 213 of the American Legion; a charter member and past president of the Tell City Kiwanis Club, and is responsible for the establishment and rapid growth of the Tell City Barbershoppers.

Among the many honors bestowed upon him are: the Boy Scout Silver Antelope—the highest award in scouting; the highest meritorious award of 1951 from the Perry County 4-H Clubs; and "Boss of the Year" title, which was presented to him at the Tell City Chamber of Commerce Distinguished Service Award and Bosses' Night banquet in 1960.

Mr. Fenn is past president and honorary life member of the Indiana Society for Crippled Children and Adults, Inc.; a member of the board of directors of the Indiana Rehabilitation Association; and numerous other organizations. From time to time he has donated land for use by community groups, including a plot of ground to the Perry County 4-H Club, and he donated the entire site for construction of the Perry County Memorial Hospital.

Certificates of Merit

Senator Jesse L. Dickinson, South Bend, Indiana.

Senator Dickinson, in addition to his legislative activities in which he worked to promote programs for the aged, the handicapped, the underprivileged, the mentally ill, and others, has been actively engaged for many years in a wide variety of community service programs. Formerly serving in the House of Representatives for three consecutive terms, Senator Dickinson was elected Senator in 1958, and is currently serving in this post. He is president of the St. Joseph County Mental Health Association, and also serves as chairman of the association's rehabilitation committee.

He has served as a member of the Indiana Mental Health Association and is currently a member of the National Association for Mental Health.

He participates on boards and voluntary committees for the Boy Scouts, Goodwill Industries, Parkview Detention Home, and the St. Joseph County Council of Community Services. He is a member of the Indiana State Nursing Home Council.

Mrs. Francelia Hamilton, Counselor, Indiana State Employment Security Division, Indianapolis, Indiana.

Mrs. Francelia Hamilton, a counselor with the Indiana State Employment Service since 1947, was one of the original members of the Indianapolis local office consulting unit. She is a graduate of the University of Illinois, where she was elected, in her sophomore year, to the International Cosmopolitan Club, a club to which only nine American students were elected each year.

She is a member of the American Association of University Women; the League of Women Voters; the American Personnel and Guidance Association; and the National Rehabilitation Association. For several years, she served as a member of the Executive Board of the Y.W.C.A.

Clarence Miller, teacher, Indiana School for the Deaf, Indianapolis, Indiana.

Clarence Miller, Indianapolis, who began teaching at the Indiana School for the Deaf in 1912, was a graduate of the school that year. He will have completed 49 years of teaching service to the school when he retires this month.

He has taught woodworking, handicraft and art metalwork, and during the summer months he assisted with the maintenance of the school. Mr. Miller has always taken a personal interest in his pupils and has demonstrated a devotion to his task that goes far beyond the requirements of his job. He has not only taught his pupils to master skills which facilitate their earning a living upon graduation, but has given them assistance, affection and personal encouragement following graduation.

Jeanette Riker, Director of Special Education, Indianapolis Public Schools, Indianapolis, Indiana.

Miss Jeanette Riker, who is credited with the success of many facets of the special education program in the Indianapolis Public Schools, has had a distinguished career in this school system as a teacher, principal, and supervisor of special education. Her work as supervisor of special education covers a period of 25 years, during which time the program has shown remarkable growth. The number of teachers of the physically handicapped has increased from 9 to 16, and the program for kindergarten and high school was added.

New areas of special education which have been added during Miss Riker's years of service are: home teaching, speech correction, the Juvenile Center program, and a program for gifted children. The over-all program during the years of Miss Riker's supervision has expanded from 60 teachers to the present 170 teachers.

She has served with ability and distinction as a member of the Governing Board of the State Federation of the Council for Exceptional Children and for six years as a member of the Governing Board of the International Council for Exceptional Children. In 1955 she received a life membership in the National Council for Exceptional Children, from the local chapter of the council.

Miss Riker has served for many years on the Board of the Indianapolis Speech and Hearing Center, and she is a member of the Juvenile Court Advisory Committee and the Advisory Council of the Noble School.

Mario Pieroni, Attorney-at-Law, Muncie, Indiana.

Mario Pieroni was graduated from the School for the Blind, Indianapolis, and took a pre-law course at Ball State Teachers College in Muncie. He later graduated from Notre Dame University School of Law and was admitted to the Delaware County Bar Association in 1940.

He has always taken a keen interest in programs designed to rehabilitate the handicapped and is immediate past president of the Indiana Society for Crippled Children and Adults, Inc. He has also served on the Board of Directors for the society.

During his term as president-elect of the society, he mapped out a program which he implemented when he became president. The four-point program which Mr. Pieroni developed and implemented was designed to assist the handicapped to achieve their place in society.

Although he has been blind since the age of three, he has learned three languages—English, Italian, and Spanish; he spearheaded a long-range program to establish more rehabilitation centers, and has worked with vigor and devotion in the Boys' Club project of the Muncie Optimist Club. He also serves as a member of the Muncie Family Service Bureau.

Conference Follow-Up

A questionnaire was prepared by the Indiana State Board of Health and sent to all persons registering for the conference, requesting their reactions and comments concerning the Governor's First Conference on the Handicapped. Following is a tabulation of the responses to this questionnaire based on a one-third (101) response as of July 3, 1961.

Question 1: Do you feel that the recent Governor's First Conference on the Handicapped was a worthwhile event?

All persons answered this question, "Yes."

Question 2: a. Do you feel that further conferences of this nature should be held?

All persons answered this question, "Yes."

b. How often?

Approximately one-half of the returns (52) indicated that a conference should be held each year. Approximately 25 percent indicated a conference should be held every other year, and another 25 percent felt such a conference should be held only as needed.

Question 3: Please list below your suggestions as to how the next conference could be improved.

Responses to this question were extremely varied and not possible to tabulate. The suggestion most often made was for additional time for the group discussion sessions. It is apparent that these sessions were too short to adequately accomplish their purpose.

Following are some of the other interesting and often conflicting responses to this question.

Have more and better preconference material which would give information concerning the agenda of the conference and the discussion groups; have one unstructured luncheon; have groups made up with all professions represented; the first half day was not needed; employ more visual aids such as displays, etc.; invite all practicing physicians; involve people on the program from all over the state; invite only professional rehabilitation workers, not interested persons; extend invitations to civic groups; time the next conference to precede the Legislature; use a statistical summary to show what is needed in the way of rehabilitation; bring in speakers from rehabilitation programs in other states; have less domination by medical leadership; invite speakers representing the Indiana Medical Association; have a state agency panel on interchange of information; shorter speeches; continuation of the same procedures used in the first conference.

Question 4: What do you consider the strong points of the conference?

Following are the major responses to this question and the number of persons making these responses.

1. The discussion groups. (21)
2. The attendance, meaning the number, type, and the diversity of the persons attending the conference. (8)
3. A beginning has been made. (5)
4. The speakers. (16)
5. The over-all positive atmosphere which prevailed at the conference. (11)
6. The fact that so many disciplines and professions actually got together and discussed the problems of rehabilitation with each other in at atmosphere of friendliness and cooperation. This was expressed by some as interdisciplinary and interagency cross-pollination. (20)

7. The Indiana University Memorial Union facilities. (4)
8. The Governor's interest and participation. (3)
9. The quality of the discussion leaders. (5)
10. The over-all organization of the conference. (7)

Question 5. What do you consider the weak points of the conference?

Here again the most frequently mentioned weakness of the conference was the lack of sufficient time for the discussion sessions. Some of the other items mentioned were as follows:

Overgeneralized goals; too much free time; the inclusion of too many people with diverse interests; lack of conclusions; conference was too short; overemphasis on physical disabilities at the expense of mental and emotional disabilities; lack of a working definition of the handicapped; too many speeches; no discussion on prevention; a lack of sense of direction; insufficient publicity and newspaper coverage.

Question 6: Please list the rehabilitation problems you feel might be possibly discussed at the next Conference on the Handicapped.

There was very little duplication in response to this question. Some of the more often mentioned problems were as follows: the employment of the handicapped; the physician's role in rehabilitation; community coordination and planning for the handicapped; a better coordination of state and private efforts in rehabilitation; barriers in communication in the rehabilitation field.

Question 7: How would you rate the accommodations of the Indiana Memorial Union for the Governor's Conference on the Handicapped?

Of the 101 reports received, 79 rated the Memorial Union accommodations as "excellent"; 14 rated them as "good"; one rated them as "fair"; with seven not answering the question.

Question 8: Do you have any suggestions to make to the Memorial Union regarding their services and facilities?

The primary suggestion for improvement was in the area of the food service. The over-all attitude was one of praise for the facilities and services of the Memorial Union.

Question 9: Where would you like to see the next conference held?

In response to this question, 63 persons indicated they would like to see the next conference also held at Indiana University, Bloomington; 33 indicated they would prefer that the meeting be held in Indianapolis; five other responses suggested other scattered locations.

In summary, the Governor's First Conference on the Handicapped appeared to be overwhelmingly endorsed by those attending as a needed program. The conferees felt that, although many improvements could and should be made, it was highly important to recognize the fact that a beginning has been made toward better cooperation and coordination of effort for the handicapped of Indiana, and that this initial effort should be followed up with future conferences of a similar nature.

Conference Statistics

Total number registering for conference	329
Number served for luncheon, May 10th	183
Number served for banquet, May 10th	220
Number served for luncheon, May 11th	157

Number attending the various group discussion sessions:

First Discussion Session, May 10th

Medical and Dental	60
Social Workers	17
Educators	30
Recreation Workers	14
Sheltered Workshop Personnel	19
Psychologists	10
Speech and Hearing Pathologists	22
Vocational Rehabilitation Counselors	47
Administrators	18
Total	237

Second Discussion Session, May 11th

Blindness and Visual Problems	13
Neurological Problems	40
Orthopedic Conditions	29
Mental Retardation	37
Speech Problems	20
Deaf and Hard of Hearing	8
Mental Illness	27
Chronic Disease	19
Total	193

MAJOR INTERESTS OF PERSONS ATTENDING THE CONFERENCE

Medicine	16
Administration	22
Occupational Therapy	19
Physical Therapy	12
Speech and Hearing Therapy	30
Nursing	19
Special Education	20
Health Education	8
Vocational Rehabilitation	33
Social Service	11
Recreation	5
Psychology	10
Tuberculosis	5
Crippled Children	15
Epilepsy	2
Blindness	12
Employment of the Handicapped	4
Mental Illness	5
Myasthenia Gravis	6
Mental Retardation	27
Students	10
Miscellaneous	38

AGENCY REPRESENTATION AT THE CONFERENCE

FEDERAL AGENCIES

Office of Vocational Rehabilitation	2
Veterans Administration and VA Hospitals	5

STATE AGENCIES

State Board of Accounts	1
Employment Security Division	3
Department of Public Instruction	
Division of Vocational Rehabilitation	26
Division of Special Education	3
Division of Mental Health	2
Agency for the Blind	6
Department of Public Welfare	5
State Board of Health	14

LOCAL GOVERNMENTAL AGENCIES

County Welfare Departments	2
Local Health Departments	7

COLLEGES AND UNIVERSITIES

Ball State Teachers College	1
Indiana State Teachers College	4
Indiana University	26
Indiana University Medical Center	18

Hospitals	
Medical Hospitals	22
Tuberculosis Hospitals	5
State Mental Hospitals	13
State Residential Schools	
Muscatatuck State School	4
Fort Wayne State School	8
Indiana School for the Blind	1
Indiana School for the Deaf	5
Schools	
Private	2
Public	26
Other Agencies	
Goodwill Industries	12
Sheltered Workshops	1
Rehabilitation Centers	8
Therapy Centers	3
Speech and Hearing Centers	1
Labor Unions	2
Churches	5
Voluntary Agencies	47
Miscellaneous	39
Total	329

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